STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
		155203	B. WING			07/30/	2012
			p. white		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	8	l		ARKS AVE		
HILLCRE	ST VILLAGE				RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	F	PREFIX	EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIAT		COMPLETION
	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
F0000	This visit was fo Complaint IN00 Complaint IN00 Federal/state def allegations are ci and F441. Unrelated deficie	112898 - Substantiated. Ticiencies related to the lited at F157, F279, F309 encies are cited.  12 25, 26, and 30, 2012  13 2000110  15 155203  16 200271120  17 20 ennie Bartelt, RN  18 200271120  19 200271120  20 200271120	F000		Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. Please accept this plan of correction as our credible allegation of compliance. Plea find enclosed the plan of correction for survey ending Jr. 30, 2012. Due to the low scop and severity of the survey find please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confit the facility's allecgation of compliance. Thus, the facility respectfully requests the grant of paper compliance.	se uly e ing, ne	DATE
	Sample: 6						
	These deficienci	es reflect state findings					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000110

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 08/16/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED			
		155203	B. WING		07/30/2012			
NAME OF F	PROVIDER OR SUPPLIE			ADDRESS, CITY, STATE, ZIP CODE	-			
			203 SPARKS AVE					
HILLCRE	ST VILLAGE		JEFFEI	RSONVILLE, IN 47130				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
	cited in accordar	nce with 410 IAC 16.2.						
	Quality review of	completed on August 1,						
	2012 by Bev Far							
		,						
			I	1				

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Event ID: MOOX11

Facility ID: 000110

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	OF CORRECTION	IDENTIFICATION NUMBER:  155203	A. BUILI	DING	00	COMPLETED 07/30/2012	
		100200	B. WING			017007	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HILLCRE	ST VILLAGE				ARKS AVE RSONVILLE, IN 47130		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	_	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
F0157	483.10(b)(11)						
SS=D	NOTIFY OF CHA	ANGES					
	(INJURY/DECLIN	NE/ROOM, ETC)					
	A facility must im	mediately inform the					
		with the resident's physician;					
		tify the resident's legal					
		an interested family					
		ere is an accident involving					
		th results in injury and has					
	-	equiring physician gnificant change in the					
		al, mental, or psychosocial					
		erioration in health, mental,					
	•	status in either life					
	threatening cond						
	complications); a	need to alter treatment					
	significantly (i.e.,	a need to discontinue an					
	existing form of to	reatment due to adverse					
	•	or to commence a new form					
	·	a decision to transfer or					
	•	sident from the facility as					
	specified in §483	3.12(a).					
		also promptly notify the					
		nown, the resident's legal					
	•	interested family member					
		change in room or roommate					
		pecified in §483.15(e)(2); or					
		dent rights under Federal or					
		lations as specified in					
	paragraph (b)(1)	of this section.					
	The facility must	record and periodically					
		ess and phone number of the					
	resident's legal re	epresentative or interested					
	family member.						
	Based on record	review and interview, the	F015	57	F-157 It is the practice of this		08/29/2012
		ensure the physician was			provider to immediately infor		
		or possible treatment of			resident, consult with the		
	_	-			residents physcian, and if		
	_	. (Resident B). The			known, notify the residents		
	facility also failed	d to follow up on			legal representative or an		

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Event ID: MOOX11

Facility ID: 000110

If continuation sheet Page 3 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPLETED	
		155203	A. BUIL		<del></del>	07/30/2012	
			B. WING				
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
					ARKS AVE		
HILLCRE	EST VILLAGE			JEFFEI	RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLE	ΓΙΟΝ
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	3
	information fax	ed to the physician related			interested family member wh	ien	
		oval of a resident's urinary			there is an accident involving		
	_	-			the resident which results in		
	· ·	lent F) The deficient			injury and has the potential f	or	
	_	d 2 of 6 residents reviewed			requiring physician		
	related to physi	cian notification in a			intervention; a significant		
	sample of 6.				change in the residents		
					physical, mental or		
	Findings includ	e·			psychosocial status a need t		
	1 manigs merad				alter treatment significantly	or	
	4 701 11 1	10 7 11 17			a decision to transfer. What		
	reviewed on 7/2	25/12 at 1:15 p.m.			-		
						۱	
	The Weekly Sk	in Assessment, dated			1		
	1	· ·				is	
	-				I -		
	[right] [arrow p	ointing up - upper] arm."					
						l I	
	The Weekly Sk	in Assessment, dated			-		
	7/10/12, indicat	ted a check mark "No"					
						l I	
		signed by the Director of					
	Nursing.					f	
					condition/notification		
	Nurses Notes, d	lated 7/15/12 at 1:15 p.m.,			of Physician/family by the		
	indicated, "Res	ting abed - rashy area			DNS/designee no later than		
	remains to [arro	ow pointing up - upper] rt					
	-				<u> </u>		
	1				_		
						.	
	otner area noted	1."				.0	
The Weekly Skin Assessment, dated							
	7/16/12, indicated next "Yes" for					""	
	Discoloration/Rashes, "To [arrow						
					-		
	sample of 6.  Findings includ  1. The clinical reviewed on 7/2  The Weekly Sk 7/9/12, indicate Discoloration/R [right] [arrow p  The Weekly Sk 7/10/12, indicate next to Discoloration assessment was Nursing.  Nurses Notes, 6 indicated, "Resiremains to [arro [right arm] - sea [complains of] other area noted.  The Weekly Sk 7/16/12, indicated Discoloration/R	record for Resident B was 25/12 at 1:15 p.m.  in Assessment, dated d next to "Yes" for tashes, "Rash to chest & Rointing up - upper] arm."  in Assessment, dated ded a check mark "No" ration/Rashes. The asigned by the Director of the dated 7/15/12 at 1:15 p.m., ting abed - rashy area ow pointing up - upper] rt attered to rt shoulder - c/o itching. [Symbol for no] d."  in Assessment, dated ded next "Yes" for			change in the residents physical, mental or psychosocial status a need of alter treatment significantly of a decision to transfer. What corrective action(s)ill be accomplished for those residents found to have been affected by the deficient practice? Resident B's rash resolved Resident F's foley catheter has been discontinued How other residents having potential to e affected by the same deficient practice will be identified and what corrective action(s) will be taken? All resident's has the potential to affected by the alleged deficie practice. Licensed nurses were in-serviced on Change of condition/notification of Physician/family by the	or  is d. the be e be nt f	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIMIT	NDIC.	00	COMPL	ETED
		155203	A. BUILE B. WING			07/30/	2012
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ARKS AVE		
	ST VILLAGE				RSONVILLE, IN 47130		
HILLONE	OT VILLAGE			JEFFER	NOONVILLE, IN 47 130		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG			DATE
	R [right] arm.				were in-serviced on change o	f	
					condition/notifications of		
	Nurses Notes, d	ated 7/16/12 at 11:00			Physician/family by the		
	-	"Pt abed up ad lib [as			DNS/designee no later than 8/10/12. Post test included.		
	_	t arm remain c/o itch.			Twenty-four hour report sheet	's	
	_				new orders and documentation		
	[Symbol for no]	[SIC] C/O.			will be reviewed daily by		
					the DNS/designee to identify		
	Nurses Notes, d	ated 7/17/12 at 2:15 a.m.,			residents with a change in		
	indicated, "Rest	ing abed. Red rashy area			condition. Residents identif		
	remains to [arro	w pointing up - upper] rt			will be further reviewed to ens		
	arm & chest. C	O itching."			Physician/family notification w	/as	
		8			completed and timely.  Non-compliance will result in		
	Nurses Notes d	ated 7/17/12 at 11:00			further education including		
	1				disciplinary action.		
	1 *	"Resting abed up ad lib.			DNS/designee responsible to		
	_	rrow pointing up - upper]			ensure compliance. How the		
	arm and chest.	C/O itch area washed soap			corrective action(s) will be		
	& H2O [water]	pt states relief of itch @			monitored to ensure the		
	this time."				deficient practice will not red	cur,	
					i.e., what quality assurance		
	The Weekly Ski	n Assessment, dated			program will be put into place		
	1	ed next to "Yes" for			The DNSand/or designee w		
	· ·				complete Change of Condition weekly x 4 weeks, monthly x 6		
		ashes, "Appears to be heat			months and quarterly thereaft		
	_	lateral upper extremities]			for any resident identified fron		
		ation indicated, "This			new orders, 24hour report she		
	writer believes r	ash related to Res.			and documentation reviewed.		
	[resident] wearing	ng jacket out to smoke in			Findings from the CQI proces	s	
	hot temperatures	s." The assessment was			will be reviewed monthly and		
		aff Development			action plan will be implemented	ed	
	Coordinator.				for threshold below 95%.		
	Coordinator.						
	Normala Nister	1-4-17/19/12 -4 2:00					
	Nurse's Notes, dated 7/18/12 at 2:00 a.m.,						
	indicated, "Res abed watching TVRash						
	_	w pointing up] R arm &					
	chest. Cleansed	area [symbol for with]					

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If continuation sheet

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	OF CORRECTION	IDENTIFICATION NUMBER:  155203	A. BUILDING  B. WING			COMPLETED 07/30/2012	
	PROVIDER OR SUPPLIER		b. Wilv	STREET A	ADDRESS, CITY, STATE, ZIP CODE  ARKS AVE		
(X4) ID	ST VILLAGE SUMMARY ST	TATEMENT OF DEFICIENCIES	<u> </u>	JEFFEF ID	RSONVILLE, IN 47130		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	COMPLETION DATE
	soap & H2O lotio	on applied for c/o itch."					
	physician was no rash (noted on 7/9 with itching (note	failed to indicate the tified of the resident's 9/12), followed by rash ed on 7/15/12), until the er visited on 7/20/12.					
	7/20/12, indicated on chest & RUA pruritic noticed b today. O [objecti pink dry papular [assessment/plan]						
	7/20/12, indicated	elephone Orders, dated d, "Betamethasone cream O X 7d [seven days]					
	Care Plan," origin most recently upon interventions includes "Assess and documents."	Impaired Skin Integrity nally dated 1/24/12, and dated 6/26/12, indicated luding, but not limited to, ament skin condition eded, notify MD of ss."					
	completed on 7/3	at the Exit Conference 30/12 at 9:00 a.m., the ng indicated she had					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155203	B. WIN	IG		07/30/	2012
NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					ARKS AVE		
HILLCRE	ST VILLAGE			JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ord, and the physician					
	would not have b	been notified of the rash					
	•	ce it was managed by					
	washing and lotion	on.					
	2. The clinical re	ecord for Resident F was					
	reviewed on 7/25	5/12 at 1:50 p.m.					
	Nurse's Notes for	r 6/26/12, beginning at					
	8:30 a.m., indica	ted the resident					
	complained of ab	odominal pain and feeling					
	_	wed by a 10:30 a.m. note					
	•	e resident complained of					
	nausea and incre	•					
		s needed antiemetic was					
		d a call was placed to the					
		:30 p.m., the resident					
		nplain of abdominal					
		a second call was placed					
	to the physician.						
	NI NI /	(10(110 -4 10 40					
		6/26/12 at 12:40 p.m.,					
		[new orders] rec'd					
		d] noted to anchor 16 Fr					
		[Foley catheter] to BSD					
	-	e]. Dx [diagnosis]					
	_	. Monitor output X 3					
	days, then notify	MD. F/C care q shift"					
	A Nurse's Note of	on 6/26/12 at 3:00 p.m.,					
	indicated the Fol	ey catheter was anchored					
	with 250 cc gold						
	immediately retu	-					
	,						

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	OF CORRECTION	IDENTIFICATION NUMBER:  155203	A. BUILDING  B. WING				COMPLETED 07/30/2012	
		100200	B. WIN			01/30/	2012	
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
HILLCRE	ST VILLAGE				ARKS AVE RSONVILLE, IN 47130			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE	
		n 6/29/12 at 2:30 p.m.,						
		its for past 3 days						
	forwarded to [nai	me of resident's						
	physician's] offic	e. Awaiting return call."						
	Documentation in	n Nurse's Notes,						
	Physician Progre	ss Notes, and Physician's						
	Telephone Order	s failed to indicate the						
	physician's respo	nse to the forwarded						
	information.							
	A Nurse's Note o	n 6/29/12 at 4:00 p.m.,						
	indicated the Nur	rse Practitioner visited,						
	but the note did n	not indicate the						
	information was	provided to the Nurse						
		nat a response to the						
		nation was provided.						
	The Physician's F	Progress Note, dated						
	6/29/12, did not a	address the Foley						
	catheter and the f	Forwarded information						
	about the urinary	output.						
	The Physician's F	Progress Note, dated						
	7/14/12, indicated	d, "S [subjective]:Has						
	had Foley cath [c	eatheter] in for 3 weeks.						
	Wishes to have re	emovedA/P						
	[Assessment/Plan	n]Urinary retention -						
	-	ey Monitor [symbol for						
		ded] straight cath for						
	retention."	. ·						
	A Physician's Tel	lephone Order, dated						
	7/14/12, included	l, but was not limited to,						

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	OF CORRECTION IDENTIFICATION NUMBER:  155203	A. BUILDING  B. WING	00	COMPLETED 07/30/2012				
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE  203 SPARKS AVE  JEFFERSONVILLE, IN 47130						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE				
	"D/C [discontinue] Foley Monday 7/16/12. PRN straight cath q shift [every shift] (8 [symbol for hours]) prn. If has [sic] to do more than 3 Xs re-anchor Foley."  This Federal tag relates to Complaint IN00112898.  3.1-5(a)(3)							

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		155203	B. WING	IIVO	<del></del>	07/30/	2012
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ARKS AVE		
HILLCRE	ST VILLAGE				RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(7/5)
PREFIX		CY MUST BE PERCEDED BY FULL		REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΕ	DATE
F0279	483.20(d), 483.2	<u> </u>		1710			DATE
SS=D	DEVELOP COM	PREHENSIVE CARE					
	PLANS						
	•	se the results of the evelop, review and revise the					
		ehensive plan of care.					
	resident's compr	cherisive plan of care.					
	The facility must	develop a comprehensive					
	•	ch resident that includes					
	•	ctives and timetables to					
		s medical, nursing, and					
		hosocial needs that are					
	identified in the d	comprehensive assessment.					
	The care plan mu	ust describe the services that					
	are to be furnishe	ed to attain or maintain the					
	resident's highes	st practicable physical,					
		chosocial well-being as					
		483.25; and any services					
		wise be required under					
		not provided due to the se of rights under §483.10,					
		nt to refuse treatment under					
	§483.10(b)(4).	it to relace treatment under					
		review and interview, the	F0279	)	F-279 It is the practice of this	i	08/29/2012
		ensure care was planned			provider to use the results of		
	_	with itching (Resident B)			the aassessments to develop	*	
		ition (Resident F). The			review and revise the residen	its	
		e affected 2 of 6 residents			comprehensive plan of care. The comprehensive plan of		
	*	to care planning in a			care includes measurable		
		to care planning in a			objectives and timetable to		
	sample of 6.				meet athe residents medical,		
	Findings include				nursing and mental and		
	i mamga merade	•			psychosocial needs that are identified in the comprehensi	ivo	
	1 The clinical re	ecord for Resident B was			assessment. What corrective		
	reviewed on 7/25				action(s) will be accomplishe		
	TOVICWED OII //23	1.12 at 1.13 μ.m.			for those residents found to		
	The Weelshy Clair	Assassment deted			have been affected by the		
	THE WEEKIY SKII	n Assessment, dated			deficient practice? · Resider	nt	

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Facility ID: 000110

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT	TPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		00	COMPLE	ETED
		155203	A. BUILDI	NG		07/30/2	2012
			B. WING	TDEET	DDDEGG GITY GTATE ZID GODE		
NAME OF	PROVIDER OR SUPPLIE	ER			DDRESS, CITY, STATE, ZIP CODE		
	-0.7.44.4.05				ARKS AVE		
HILLCRE	EST VILLAGE		J	EFFER	RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	Т	AG	DEFICIENCY)	12	DATE
	7/9/12, indicate	d next to "Yes" for			B care plan is in place relating	to	
		Rashes, "Rash to chest & R			current skin condition. ·		
		ointing up - upper] arm."			Resident F's care plan has be	en	
					reviewed and updated and		
		and nursing progress			reflects current condition. Ho	w	
		ndicate further assessment			other residents having the		
	of the area.				potential to e affected by the		
					same deficient practice will be		
	The Weekly Sk	in Assessment, dated			identified and what correctiv		
	I -	ted a check mark "No"			action(s) will be taken? · All		
	1	ration/Rashes. The			residents have the potential to affected by the alleged deficie		
					practice. Licensed nurses	111	
		signed by the Director of			were in-serviced on developing	a	
	Nursing.				plan of care for residents when	_	
					completing a telephone order		
	Nurses Notes, d	lated 7/15/12 at 1:15 p.m.,			indicating a change of condition	n	
	•	ting abed - rashy area			by the DNS/designee no later		
	1	ow pointing up - upper] rt			than 8/27//12. Post test include		
	_				· 100% audit of care plans we		
	1 2	attered to rt shoulder - c/o			completed on or before 8/29/1		
	1 2	itching. [Symbol for no]			Orders will be reviewed in clin		
	other area noted	1."			meeting to ensure care plan w completed as needed,	as	
					Non-compliance will result in		
	The Weekly Sk	in Assessment, dated			further education including		
	1	ted next "Yes" for			disciplinary action.		
	· ·	Cashes, "To [arrow			DNS/designee is responsible to	to	
		· -			ensure compliance. What		
		est & [arrow pointing up]			measures will be put into pla	ce	
	R [right] arm.				or what systemic changes w	ill	
					be made to ensure that the		
	Nurses Notes, d	lated 7/16/12 at 11:00			efficient practice does not		
	p.m., indicated.	"Pt abed up ad lib [as			recur? · Licensed nurses we	-	
	desired]. Rash rt arm remain c/o itch.				in-serviced on developing plan	of	
	-				care for residents when		
[Symbol for no] [sic] c/o."				completing a telephone order			
	Nurses Notes, dated 7/17/12 at 2:15 a.m.,				indicating a change of condition	on	
					by the DNS/designee no later than 8/27/12. Post test include		
	indicated, "Resi	ting abed. Red rashy area			· 100% audit of care plans we		
	remains to [arro	ow pointing up - upper] rt			completed on or before 8/29/1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	ETED
		155203	B. WIN			07/30/2	2012
		L	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹					
LIII L CDE	CTVILLACE				ARKS AVE RSONVILLE, IN 47130		
HILLORE	ST VILLAGE			JEFFER	RSONVILLE, IN 47 130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	arm & chest. C/	o itching."			<ul> <li>Orders will be reviewed in</li> </ul>		
					clinical meeting by the		
	Nurses Notes da	ated 7/17/12 at 11:00			DNS/designee to ensure care		
		"resting abed up ad lib.			plan was completed as neede	d. ·	
		• •			Non-compliance will result in further education including		
	_	row pointing up - upper]			disciplinary action.		
		C/o itch area washed soap			DNS/designee is responsible t	.o	
		ot states relief of itch @			ensure compliance. How the		
	this time."				corrective action(s) will be		
					monitored to ensure the		
	The Weekly Skir	n Assessment, dated			deficient practice will not rec	ur,	
	1	ed next to "Yes" for			i.e., what quality assurance		
	•	ashes, "Appears to be heat			program will be put into plac		
					The CQI audit tool for care p		
	_	ateral upper extremities]			updating will be utilized weekly		
		ation indicated, "This			4 weeks, monthly x 6 months a	and	
	writer believes ra	ash related to Res.			quarterly thereafter for any resident identified from new		
	[resident] wearir	ng jacket out to smoke in			orders, 24hour report sheets, a	and	
	hot temperatures	s." The assessment was			documentation reviewed.		
	signed by the Sta	aff Development			Findings from the CQI process	,	
	Coordinator.				will be reviewed monthly and a		
	Coordinator.				action plan will be implemente	d	
	Numaala Nataa d	atad 7/19/12 at 2:00 a m			for threshold below 95%		
	· ·	ated 7/18/12 at 2:00 a.m.,					
		abed watching TVRash					
	_	pointing up] R arm &					
	chest. Cleansed	area [symbol for with]					
	soap & H2O, lot	ion applied for c/o itch."					
	Documentation i	in the record failed to					
		sician was notified of the					
		noted on 7/9/12), followed					
	· ·	· · · · · · · · · · · · · · · · · · ·					
	-	ning (noted on 7/15/12),					
		Practitioner visited on					
	7/20/12.						
	The Physician's	Progress Notes, dated					
	l		1				

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00		ETED	
		155203	B. WIN			07/30/	07/30/2012	
C OF P					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIEF	R		203 SP	ARKS AVE			
HILLCRE	ST VILLAGE				RSONVILLE, IN 47130			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
	•	ed, "S [subjective]: Rash						
	on chest & RUA	[right upper arm]						
	pruritic noticed l	by staff & pt. [patient]						
	today. O [object	tive]: Confluent spotty						
	pink dry papular	rash A/P						
	[assessment/plan	n] - Eczema						
	1 -	[sic] cream BID [twice						
	daily]."	£ 3						
	7.1.							
	The Physician T	elephone Orders, dated						
		ed, "Betamethasone cream						
		D X 7d [seven days]						
	1	e Care Plan Update						
		•						
		der was blank and failed						
	_	n related to the care of the						
	resident's rash w	ith itching.						
	The "At Risk for	Impaired Skin Integrity						
	Care Plan," origi	inally dated 1/24/12, and						
	most recently up	odated 6/26/12, failed to						
	indicate a plan re	elated to the resident's						
	rash with itching							
		•						
	During interview	v on 7/26/12 at 2:30 p.m.,						
	the Director of N	Nursing indicated the care						
		ne resident's rash should						
	_	Care Plan Update section						
		's Telephone Order.						
		-F						
	2. The clinical r	ecord for Resident F was						
		5/12 at 1:50 p.m.						
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							
	Nurse's Notes fo	or 6/26/12, beginning at						
	8:30 a.m., indica							
	0.50 a.m., mulca	and the resident						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155203			LDING	NSTRUCTION  00	(X3) DATE COMPL <b>07/30</b> /	ETED	
	PROVIDER OR SUPPLIER		p. w.i.v	STREET A	DDRESS, CITY, STATE, ZIP CODE ARKS AVE SONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	Ε	(X5) COMPLETION DATE
	of fullness, followith that indicated the nausea and incredistention. An auxiliary administered, and physician. At 12 continued to condiscomfort, and at to the physician.  Nurse's Note on indicated, "N/O's [received] et [and [french]. F/C can to BSD [bedside [diagnosis] urina output X 3 days, care q shift"  A Nurse's Note of indicated the Followith 250 cc gold immediately returned at the physician and physician's complete of the physician of the physician Progret Telephone Order.	s needed antiemetic was d a call was placed to the 2:30 p.m., the resident aplain of abdominal a second call was placed  6/26/12 at 12:40 p.m., s [new orders] rec'd all noted to anchor 16 Fr re cc F/C [Foley catheter] drainage]. Dx ry retention. Monitor then notify MD. F/C  on 6/26/12 at 3:00 p.m., ey catheter was anchored en yellow urine arned.  on 6/29/12 at 2:30 p.m., atts for past 3 days me of resident's ee. Awaiting return call."					

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	NT OF DEFICIENCIES OF CORRECTION	i '		DING	NSTRUCTION 00	(X3) DATE COMPL <b>07/30</b> /	ETED
	PROVIDER OR SUPPLIER		B. WING	STREET A	ARKS AVE RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	information.						
	indicated the Number the note did note the forwarded in The Physician's l	on 6/29/12 at 4:00 p.m., rse Practitioner visited, not indicate a response to formation.  Progress Note, dated address the Foley					
	•	forwarded information					
	7/14/12, indicate had Foley cath [o Wishes to have r [Assessment/Pla Trial remove Fol	Progress Note, dated d, "S [subjective]:Has eatheter] in for 3 weeks. emovedA/P n]Urinary retention - ey Monitor [symbol for ded] straight cath for					
	7/14/12, included "D/C [disconting 7/16/12. PRN standshift] (8 [symbol do more than 3 X) Care Plan Update	lephone Order, dated d, but was not limited to, nue] Foley Monday raight cath q shift [every for hours]) prn. If has to Ks re-anchor Foley." The e section of the bhone Order form was					
	sleeve in the clin	re plans were in a plastic ical record. The care dicate a plan related to					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155203				MULTIPLE CO JILDING ING	00	C	OATE SURVEY OMPLETED 7/30/2012
NAME OF PROVIDER			•	203 SP	ADDRESS, CITY, STATE, ZI ARKS AVE RSONVILLE, IN 47130		
· · · · · · · · · · · · · · · · · · ·	ACH DEFICIEN	ATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
to the cathet	discontinua	ent of the resident related ation of the Foley bing monitoring for					
RN #6 know needs assiste staff k  Durin the Di was needs Reside	6 indicated about her note. The nurse ed to toilet to know if she ag interview irector of Note care plantlent F for ur federal tag r 112898.	on 7/25/12 at 4:16 p.m., Resident F lets staff eeds, including toileting indicated the resident is hroughout the day, so voids.  on 7/26/12 at 2:30 p.m., ursing indicated there related to monitoring inary retention.  elates to Complaint					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE COMPL	
AND PLAN	OF CORRECTION		A. BUII	LDING	00		
		155203	B. WIN	G		07/30/	2012
NAME OF 1	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
	-0.7.111.4.0.5				PARKS AVE		
HILLCRE	EST VILLAGE			JEFFE	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0309	483.25	-/OFDV/IOFO FOR LIJOUFOT					
SS=D	WELL BEING	E/SERVICES FOR HIGHEST					
		ust receive and the facility					
		necessary care and					
		n or maintain the highest					
	practicable phys						
		II-being, in accordance with ive assessment and plan of					
	care.	ive assessment and plan of					
		ation, record review, and	F03	09	F309 It is the practice of this		08/29/2012
		cility failed to assess,			provider to provide the necess	sary	
	*	orders, and/or provide			care and services to attain or		
		related to skin care for 2			maintain the highest practicab		
		viewed related to skin			physical, mental and psychos well being in accordance with		
					comprehencisve assessmetn		
	care needs. (Res	*			will be accomplished for those		
	_	failed to clarify and/or			residents found to have been		
		planned related to			affected by the deficient practi		
	_	ls for 1 of 1 resident			What corrective action(s) will I accomplished for those reside		
		to swallowing and			found to have been affected b		
	•	s in the sample of 6			the deficient practice? Reside	•	
	residents. (Resid	dent D)			D is receiving nectar thickene		
					liquids only, no longer receive		
	Findings include				thin liquids and speech theraphas discharged resident relate		
					hospice status. Resident is	,u 10	
	1. A. During Ini	tial Tour on 7/25/12,			wearing Geri- sleeves at all tir	nes.	
	which began at 1	1:45 a.m., Resident D			The care plan and c.n.a.		
	was observed in	a Broda chair with his			assignment sheet has also be		
	breakfast tray wi	thin the resident's reach			updated to include current pla care relating to thickened liqui		
	in front of him o	n his overbed table. Care			and Geri- sleeves. Resident		
	for the resident b	by CNA #3 and LPN #4			care plan and c.n.a. assignme		
	was observed an	d was completed at 12:35			sheet has been updated to		
		e, the resident requested			include current plan of care		
	-	#4 indicated the resident			relating to skin. How other residents having the potential	to	
	· ·	d liquids. LPN #4			be affected by the same defici		
		#3 go to the dining room			practice will be identified and		

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	OF CORRECTION  DESCRIPTION  DES	(X2) MULTIPLE CC		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	a. building 00		COMPLETED		
	155203	B. WING 07/30/2012				
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE			
			ARKS AVE			
HILLCRE	EST VILLAGE	JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG				
	to obtain the fluids. LPN #4 indicated		what corrective action(s) will b			
	usually thickened water was in the		taken? · All residents have t			
	refrigerator in the pantry, but Resident D		potential to be affected by the alleged deficient practice.			
	does not like thickened water. She		Licensed Nursing staff has be	en		
	indicated the resident will drink the		in-serviced on following			
			physician's orders and plan of			
	thickened juices available in the dining		care by the DNS/designee no			
	room. During care, LPN #4 indicated to		later than 8/27/12. Post test			
	the resident that she would wash his face		included. CNA assignment			
	to remove breakfast food debris from		sheets and care plans have be	een		
	around the resident's mouth. During		updated to ensure all interventions are in place. • A	All		
	interview as CNA #3 prepared to remove		physician orders are reviewed			
	Resident D's breakfast tray from the		daily by the DNS/designee.			
	room, she indicated the liquids on the tray		Physician orders are in place	and		
	were a cup of thickened juice, two cups of		are being followed.			
	thin water, one with a straw, and an		Non-compliance with these			
			practices will result in further			
	insulated cup with lid, which contained		education including disciplinar	У		
	thin water.		action. Director of nursing	blo		
			services/designee is responsil to ensure compliance. What	OIC		
	On 7/25/12 at 4:05 p.m., CNA #5 was		measures will be put into place	e or		
	observed leaving Resident D's room. She		what systemic changes will be			
	indicated the resident was on thickened		made to ensure that the defici			
	liquids, so she did not leave him any		practice does not recur? ·			
	fluids at the bedside, since he could drink		Licensed Nursing staff has be	en		
	fluids on his own. She indicated the		in-serviced on following			
			physician's orders and plan of	<b>I</b>		
	resident could have regular water between		care by the DNS/designee no later than 08/27/12. Post test			
	meals. She pulled her assignment sheet		included. The charge nurse			
	from her pocket, reviewed the sheet, and		responsible for ensuring care			
	indicated information about the liquids		intervention and CNA assignm			
	was not on the sheet. She indicated the		sheets are in place and will			
	nurse had instructed her about the liquids.		conduct rounds each shift. · A	<b>I</b>		
	During interview after the CNA left, the		physician orders are reviewed			
	resident indicated he wanted a drink of		daily by the DNS/designee wit			
	water.		follow-up using the CQI minute tool to ensure physician orders			
	water.		are in place and being followe			
			a. s place and being followe	~.		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLETED	
		155203	A. BUI B. WIN			07/30/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	1			ARKS AVE		
HILLORE	ST VILLAGE				RSONVILLE, IN 47130		
					(OOIVILLE, IIV 47 100		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·	DATE	
		10 p.m., LPN #10			<ul> <li>Non-compliance with these practices will result in further</li> </ul>		
	indicated the resi	ident could have free			education including disciplinar	N/	
	water between m	neals, but not within 45			action. How the corrective	y	
	minutes of the m	eal.			action(s) will be monitored to		
					ensure the deficient practice w	vill	
	The clinical reco	rd for Resident D was			not recur, i.e., what quality		
					assurance program will be put		
	reviewed on 7/25	5/12 at 2.23 p.m.			into place? · The CQI audit to for altered fluid consistency an		
	The Speech The	rapist Progress Note,			skin management will be utilize		
	_	dicated the resident			monthly for 4 weeks, monthly		
	•				6 months and quarterly therea	fter.	
		speech therapy services			<ul> <li>Findings from the CQI proce</li> </ul>		
	on 6/11/12, with focus on "Treatment of				will be reviewed monthly and a		
		unction and/or oral			action plan will be implemente	d	
	function for feed	ing." "Precautions" on			for threshold below 95%.		
	the note indicate	d, "No thin liquids,					
	unless on water t	protocol after proper oral					
	^	nded liquids consistency					
		quids (NTL), straws ok."					
	is neetal tiller if	quius (IVIL), siiaws ok.					
	The significant c	hange Minimum Data					
	_	dated 5/21/12, indicated					
	•	the swallowing disorder					
		mptoms of "Loss of					
		•					
	_	m mouth when eating or					
	drinking."						
	The Physician To	elephone Order, dated					
	1	•					
	· · · · · · · · · · · · · · · · · · ·	d, "ST [speech therapy]					
		et [symbol for change]:					
		texture, downgrade					
	liquid consistenc	y to nectar thick, straws					
	ok. 2. ST to tx [1	treat] for dysphagia					
	_	owing] 5X/wk [week] for					
	4 wks [weeks]."	O					

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PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTION CEACH CEACH CEACH CEACH CEACH CORRECTION CEACH	X5) LETION ATE
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  203 SPARKS AVE  JEFFERSONVILLE, IN 47130  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  203 SPARKS AVE  JEFFERSONVILLE, IN 47130  (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DA  DA  OF THE PROPRIATE DEFICIENCY DEFICIENCE DEFICIENCY DEFICIENCE	LETION
NAME OF PROVIDER OR SUPPLIER  HILLCREST VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  DA  203 SPARKS AVE  JEFFERSONVILLE, IN 47130  (EACH OF CORRECTION OF CORRECTION OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG DEFICIENCY)  DA  10 PROVIDER'S PLAN OF CORRECTION OF COMPACTOR	LETION
HILLCREST VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  JEFFERSONVILLE, IN 47130  (EACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DA  DA  DA  DA  DA  DEFICIENCY  D	LETION
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY  DA  O  D  D	LETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DA	
THE RESIDENT ON ESCHEDENT PROBLEM TO A SHARING THE SHA	ATE.
The most recent Physician Telephone	
The most recent rhysician relephone	
Order related to the resident's liquids was	
signed by the speech therapist on 7/12/12,	
and indicated, "Speech Therapy to	
continue swallowing therapy 3 X /week	
for 4 weeks, recertification period of	
7/11/12 - 8/9/12. Effective date: 7/11/12.	
2. Trials of thin liquids [symbol for with]	
SLP [Speech Language Pathologist]	
only." The Care Plan Update section of	
the Physician Telephone Order indicated,	
"Problem: dysphagia; Goal: 1. Least	
restrictive diet/liquid consist.	
[consistency] [symbol for with] min	
[minimal] S/S [signs and symptoms]	
aspiration. 2. Adequate hydration, remain	
pneumonia free. 3. Return to thin liquids	
when safe. Intervention: Skilled swallow	
tx [treatment], swallow strategies,	
education."	
The Occupational Therapist Progress	
Report and Updated Plan of Care, dated	
7/12/12, indicated in "Current Level of	
Function" related to "Self Feeding -	
General," "The patient is able to feed self	
after set-up"	
During interview on 7/26/12 at 11:45	
a.m., the Medical Records Nurse	
indicated the most recent physician's	
order for the resident related to fluids was	
for nectar thick liquids and thin liquids	

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	OF CORRECTION	IDENTIFICATION NUMBER:  155203	A. BUII	LDING	00	COMPLETED 07/30/2012	
		100200	B. WIN			017007	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HILLCRE	ST VILLAGE				ARKS AVE RSONVILLE, IN 47130		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ē	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	with the speech t	herapist only.					
	B. During Initial began at 11:45 a. observed in a Browas wearing a shrishle on his arm the left arm in the interview at this the resident had a skin tear that more CNA #3 were ob Resident D to be assisted the resident of t	Tour on 7/25/12, which m., Resident D was oda chair. The resident nort sleeved shirt, and n was a white bandage to e elbow area. During time, LPN #4 indicated a fall which resulted in a rning, and LPN #4 and served transferring d. LPN #4 and CNA #3 ent with donning a clean nt was not assisted to and after care was 35 p.m., the staff left the 25 p.m., Resident D was boom in his low bed. He geri-sleeves.  245 a.m., Resident D was boom in his low bed. He geri-sleeves.  250 p.m., Resident D was boom in his low bed. He geri-sleeves.					

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	of correction identification number:  155203	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPI 07/30	ETED
	PROVIDER OR SUPPLIER EST VILLAGE	203 SP	ADDRESS, CITY, STATE, ZIP CODE ARKS AVE RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE	(X5) COMPLETION DATE
	The most current physician's rewrite orders, signed 6/6/12, included, but were not limited to, "Geri-sleeves to bilateral arms."				
	The Careplan Worksheet, originally dated 11/29/11, and most recently updated 5/29/12, indicated, "The resident is at risk for skin tears" Interventions included, but were not limited to, "Geri-sleeves B [bilateral] arms at all times."				
	The Treatment Administration Record (TAR) and Nurse's Notes for July 2012 did not indicate the resident refused the gerisleeves. The TAR indicated with a nurse's initials that the gerisleeves were on the bilateral arms on three shifts on 7/25/12 and on the 7:00 a.m. to 3:00 p.m. shift on 7/26/12.				
	2. On 7/25/12 at 4:00 p.m., LPN #2 was seated at the nurse's station charting. During interview, LPN #2 indicated Resident B had rash areas on his chest and arm, which the nurse thought might be heat-related, since the resident likes to wear long sleeves and a jacket, even in hot weather. Upon request, LPN #2 was observed assessing the skin on the right side of the chest and right upper arm of Resident B. The resident was observed to have a light red slightly splotchy area on the skin of the right upper chest and right				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155203		A. BUILDING  B. WING	00	COMPLETEI 07/30/201	D
	PROVIDER OR SUPPLIER EST VILLAGE	STREET A	ADDRESS, CITY, STATE, ZIP CO ARKS AVE RSONVILLE, IN 47130	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR. (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE CO	(X5) MPLETION DATE
	upper arm.				
	The clinical record for Resident B was reviewed on 7/25/12 at 1:15 p.m.				
	The Weekly Skin Assessment, dated 7/9/12, indicated next to "Yes" for Discoloration/Rashes, "Rash to chest & R [right] [arrow pointing up - upper] arm."  The assessment and nursing progress notes failed to indicate further assessment of the area.				
	The Weekly Skin Assessment, dated 7/10/12, indicated a check mark "No" next to Discoloration/Rashes. The assessment was signed by the Director of Nursing.				
	Nurses Notes, dated 7/15/12 at 1:15 p.m., indicated, "Resting abed - rashy area remains to [arrow pointing up - upper] rt [right arm] - scattered to rt shoulder - c/o [complains of] itching. [Symbol for no] other area noted."				
	The Weekly Skin Assessment, dated 7/16/12, indicated next "Yes" for Discoloration/Rashes, "To [arrow pointing up] chest & [arrow pointing up] R [right] arm.				
	Nurses Notes, dated 7/16/12 at 11:00 p.m., indicated, "Pt abed up ad lib [as				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	00	CON	TE SURVEY MPLETED			
		155203	B. WING		07/3	07/30/2012		
	PROVIDER OR SUPPLIEF	R	STREET ADDRESS, CITY, STATE, ZIP CODE  203 SPARKS AVE  JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	desired]. Rash r [Symbol for no]	t arm remain c/o itch. [sic] c/o."						
	indicated, "Resti	ated 7/17/12 at 2:15 a.m., ing abed. Red rashy area w pointing up - upper] rt to itching."						
	p.m., indicated, 'Rash remain [arm and chest. C	resting abed up ad lib. row pointing up - upper] C/o itch area washed soap ot states relief of itch @						
	7/18/12, indicate Discoloration/Ra rash to BUE [bil & chest." A not writer believes ra [resident] wearing	n Assessment, dated ed next to "Yes" for ashes, "Appears to be heat ateral upper extremities] ation indicated, "This ash related to Res. ag jacket out to smoke in s." The assessment was aff Development						
	indicated, "Res a remain to [arrow chest. Cleansed	ated 7/18/12 at 2:00 a.m., abed watching TVRash pointing up] R arm & area [symbol for with] on applied for c/o itch."						
	•	Progress Notes, dated ed, "S [subjective]: Rash						

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE ( COMPL	
		155203	A. BUI B. WIN	LDING		07/30/	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ARKS AVE		
HILLCRE	ST VILLAGE			JEFFEF	RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		[right upper arm]		TAG	DLI ICILI (CT)		DATE
		oy staff & pt. [patient]					
	^	ive]: Confluent spotty					
	pink dry papular						
	[assessment/plan						
		sic] cream BID [twice					
	daily]."						
	The Physician To	elephone Orders, dated					
		d, "Betamethasone cream					
		X 7d [seven days]					
	dermatitis." The Care Plan Update						
	section of the order failed to indicate a						
	plan.						
	During interview	on 7/26/12 at 2:30 p.m.,					
	_	Tursing indicated skin					
	sweeps are condu	ucted monthly, and					
	routine skin asse	ssments are conducted					
	weekly. She ind	icated she did skin					
	-	Staff Development					
		skin sweeps in July 2012.					
		nen she assessed Resident					
		ittle bumps at his wrist.					
	· · · · · · · · · · · · · · · · · · ·	On the 17th [sic] [name of					
		pment Coordinator] went erash]." She indicated					
		ited to the resident's rash					
	•	l in the Care Plan Update					
		ysician's Telephone					
	Order.	Josephone					
	This Federal tag	relates to Complaint					
	IN00112898.						

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	OF CORRECTION	IDENTIFICATION NUMBER: 155203	(X2) MULTIPLE CO  A. BUILDING  B. WING	00 	COMPI			
HILLCRE	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE  203 SPARKS AVE  JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	3.1-37(a)							

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F CORRECTION OVIDER OR SUPPLIER	IDENTIFICATION NUMBER: 155203	A. BUII	LDING	00	COMPLETED	
OVIDER OR SUPPLIER	155203		DING			
OVIDER OR SUPPLIER		B. WING		·	07/30/2012	
OVIDER OR SUPPLIER	IAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE					
				ARKS AVE		
ST VILLAGE						
SUMMARY ST	TATEMENT OF DEFICIENCIES		ID BROWINED'S BLANCE COR		(X5)	
(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
REGULATORY OR  483.25(a)(3) ADL CARE PRO RESIDENTS A resident who is of daily living rece to maintain good personal and ora Based on observate record review, the residents received comfort and personal residents observed a sample of 6. (Reference of the sample of form of the side o	VIDED FOR DEPENDENT  sunable to carry out activities eives the necessary services nutrition, grooming, and I hygiene.  ation, interview, and e facility failed to ensure d services to maintain onal hygiene for 2 of 4 and receiving direct care in desidents A and D)  Tour on 7/25/12, which m., Resident D was oda chair next to his bed to tray in front of him on and tray in front of him on and the his head almost rest of his wheel chair.  Beserved outside the and lunch trays were the room was entered CNA #3. Upon entry to ident's face was observed food debris stuck around to his face. Resident D's wed to have a large stain of the pants in the lap area.	F03	TAG	F-312 It is the practice of this provider to provide the necessary services to carry of activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and of hygiene. What corrective action(s) will be accomplisher for those residents found to have been affected by the deficient practice? Resident D has clean clothing in his closs and is changed promptly when soiled, face and hands are cleaned after each meal, and resident is cleansed after each bowel movement using a washcloth or wipes. Resider A's c.n.a. assignment sheet has been updated to reflect assistance needed for toileting How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to affected by the alleged deficient practice. Nursing staff will be	DATE  DATE  DATE  08/29/2012  ut s  ral  d  nt set  he s  e s  be s  t  c  be s  c  c  c  c  c  c  c  c  c  c  c  c  c	
The stain include #4 and CNA #3 t	d pieces of food. LPN ransferred Resident D			in-serviced on personal hygien on or before 8/27/12. Post test included. · Peri care skills che	e eck	
	SUMMARY STA (EACH DEFICIENCE REGULATORY OR 483.25(a)(3) ADL CARE PRO RESIDENTS A resident who is of daily living rector maintain good personal and oral Based on observations and personal	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  483.25(a)(3)  ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  Based on observation, interview, and record review, the facility failed to ensure residents received services to maintain comfort and personal hygiene for 2 of 4 residents observed receiving direct care in a sample of 6. (Residents A and D)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  483.25(a)(3)  ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  Based on observation, interview, and record review, the facility failed to ensure residents received services to maintain comfort and personal hygiene for 2 of 4 residents observed receiving direct care in a sample of 6. (Residents A and D)  Findings include:  1. During Initial Tour on 7/25/12, which began at 11:45 a.m., Resident D was observed in a Broda chair next to his bed with his breakfast tray in front of him on his overbed table. The resident was leaning to the side with his head almost couching the arm rest of his wheel chair. A tray cart was observed outside the resident's room, and lunch trays were being delivered. The room was entered with LPN #4 and CNA #3. Upon entry to the room, the resident's face was observed to be soiled with food debris stuck around his mouth and onto his face. Resident D's pants were observed to have a large stain on the left side of the pants in the lap area.  The stain included pieces of food. LPN #4 and CNA #3 transferred Resident D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure residents received services to maintain comfort and personal hygiene for 2 of 4 residents observed receiving direct care in a sample of 6. (Residents A and D)  Findings include:  1. During Initial Tour on 7/25/12, which began at 11:45 a.m., Resident D was observed in a Broda chair next to his bed with his breakfast tray in front of him on nis overbed table. The resident was eaning to the side with his head almost couching the arm rest of his wheel chair. A tray cart was observed outside the resident's room, and lunch trays were being delivered. The room was entered with LPN #4 and CNA #3. Upon entry to the room, the resident's face was observed to be soiled with food debris stuck around nis mouth and onto his face. Resident D's boants were observed to have a large stain on the left side of the pants in the lap area. The stain included pieces of food. LPN #4 and CNA #3 transferred Resident D	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  483.25(a)(3)  ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  Based on observation, interview, and record review, the facility failed to ensure residents received services to maintain as ample of 6. (Residents A and D)  Findings include:  1. During Initial Tour on 7/25/12, which began at 11:45 a.m., Resident D was observed in a Broda chair next to his bed with his breakfast tray in front of him on its overbed table. The resident was eaning to the side with his head almost couching the arm rest of his wheel chair.  A tray cart was observed outside the resident's room, and lunch trays were been gielivered. The room was entered with LPN #4 and CNA #3. Upon entry to the room, the resident's face was observed to be soiled with food debris stuck around mis mouth and onto his face. Resident D's ants were observed to have a large stain on the left side of the pants in the lap area.  The stain included pieces of food. LPN #4 and CNA #3 transferred Resident D	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	LDING	00	COMPL	ETED
		155203	B. WIN		<del></del>	07/30/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R					
	ST VILLAGE				ARKS AVE RSONVILLE, IN 47130		
HILLORE	31 VILLAGE			JEFFER	RSONVILLE, IN 47 130		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	cloth, and indica	ated to the resident, "You			on or before 8/27/12.		
	got some of that	breakfast on ya!" as she			Non-compliance with these		
	wiped around the resident's mouth. CNA				practices will result in further		
	-	resident's brief was clean			education including disciplinar action. Director of nursing	у	
		43 indicated the resident			services/designee is responsible	nle	
	1				to ensure compliance. What		
	was also dry after breakfast when she				measures will be put into pla	ce	
		s staff prepared to change			or what systemic changes w		
	the resident's clothing, including the				be made to ensure that the		
stained pants, the closet and drawers of				deficient practice does not			
	the room were o	bserved to have no clean			recur? · Nursing staff will be	<b>:</b>	
	clothing in them	. LPN #4 indicated the			in-serviced on personal hygier		
	resident had mo				on or before 8/27/12. Post test		
	"yesterday," and she indicated apparently				included. · Peri care skills che	eck	
	1 -	**			off will be completed for		
	_	not been moved to the			C.N.A.'s DNS/designee on or		
	· · · · · · · · · · · · · · · · · · ·	would need to be			before 8/27/12. The charge nurse will be responsible for		
	obtained. The re	esident indicated he did			conducting rounds to ensure		
	not want to get b	back up to his chair for			resident personal hygiene an		
	lunch, since he l	nad been in his chair since			peri care is provided per plar		
	<u>-</u>	was completed at 12:35			of care. Non-compliance wi		
	p.m.	P			these practices will result in		
	P.III.				further education including		
	Th1:	and Compositions D			disciplinary action. · Director	of	
		ord for Resident D was			nursing services/designee is		
	reviewed on 7/2	5/12 at 2:25 p.m.			responsible to ensure		
					compliance. How the		
	The significant of	change Minimum Data			corrective action(s) will be monitored to ensure the		
	Set assessment,	dated 5/21/12, indicated			deficient practice will not rec	r	
	the resident scor	red 12 of 15 on the Brief			i.e., what quality assurance	, wii,	
	Interview for M	ental Status. The			program will be put into plac	e?	
		cated the resident required			The CQI audit tools for		
		sistance of two staff for			accommodation of needs will be	ре	
					utilized monthly for 4 weeks,		
	1	d transfers, and the			monthly for 6 months and		
		ance of one staff person			quarterly thereafter. Finding	ıs	
	for dressing and	personal hygiene.			from the CQI process will be		
					reviewed monthly and an actic	)f1	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155203		A. BUILDING B. WING			COMPLETED 07/30/2012		
	PROVIDER OR SUPPLIER		•	203 SP	ADDRESS, CITY, STATE, ZIP CODE ARKS AVE RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
IAU	The Care Plan W dated 8/30/11, an 5/29/12, indicated resident requires [moderate to max performing ADL living] due toin transfersimpair personal hygiene weakness." Interwere not limited ADLs as resident clothes that are control of the Resident Car (assignments for was provided on Special Needs list included, but went towel in lapoff in chair."  2. On 7/25/12 at observed assistint toilet. CNA #7 resident was assist toilet. The resident was assist toilet. The resident was assist toilet paper to cle from the anal/persident was also personal paper.	forksheet, originally and most recently updated d, the problem of, "The up to mod to max aximum] assist in s [activities of daily mpaired ed dressingimpairedParkinson's [disease], eventions included, but to, "Provide assist with a requiresDress in lean"  Te/Need Sheet CNAs) for Resident D 7/30/12 at 8:45 a.m. The sted for Resident D re not limited to, "Keep er to lay down if leaning 4:20 p.m., CNA #7 was g Resident A to the emoved the resident's ed the brief was wet. The sted to transfer to the ent had a bowel as observed to use dry can light brown stool rianal area. CNA #7 ilet paper to clean light at the resident's		IAU	plan will be implemented for threshold below 95%. Date of Compliance: 8/29/12		DATE

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155203	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/30/2012
	PROVIDER OR SUPPLIER EST VILLAGE	203 SP	ADDRESS, CITY, STATE, ZIP COE ARKS AVE RSONVILLE, IN 47130	DE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE COMPLETION
	perineal area, penis, and hips covered by the wet brief were not cleansed with wipes or wash cloths. The resident was assisted to don a clean pull-up.			
	The clinical record for Resident A was reviewed on 7/26/12 at 9:45 a.m.			
	The quarterly Minimum Data Set assessment, dated 6/18/12, indicated the resident was frequently incontinent of urine and occasionally incontinent of stool. The assessment indicated the resident required the extensive assistance of two staff for toilet use.			
	The Resident Care/Need Sheet (assignments for CNAs) for Resident A was provided on the Initial Tour on 7/25/12 at 11:45 a.m. The assignment for Resident A indicated the resident used incontinent briefs and was to be offered toileting.			
	During interview at the end of day conference on 7/26/12 at 5:00 p.m., the Administrator indicated she would expect a resident's skin to be cleansed with wipes or wash cloths after a wet brief was removed and the resident had a bowel movement.			
	3.1-38(a)(3)(A)			

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	OF CORRECTION	IDENTIFICATION NUMBER:  155203	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM 07/3	PLETED 80/2012
	PROVIDER OR SUPPLIER		203 SP	ADDRESS, CITY, STATE, ZIP CO ARKS AVE RSONVILLE, IN 47130	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE S	OATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED	
		155203	B. WIN			07/30/	2012	
NAME OF F	DROWINED OR CUIDNITED			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			203 SP	ARKS AVE			
	ST VILLAGE			JEFFEF	RSONVILLE, IN 47130			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0314 SS=D	483.25(c) TREATMENT/SN PRESSURE SOI Based on the cor a resident, the faresident who ent pressure sores of sores unless the demonstrates the and a resident hareceives necessare promote healing, prevent new sore Based on observatinterview, the fact interview, the fact interventions were of pressure ulcers implemented relat of the resident's a mattress for cont ulcers. The defice of 2 residents revulcers in a sample E)  Findings include  1. During Initial began at 11:45 a. observed in a Bro The room was en CNA #3. Upon or resident was obso LPN #4 and CNA During interview	CCS TO PREVENT/HEAL RES mprehensive assessment of acility must ensure that a ters the facility without loes not develop pressure individual's clinical condition at they were unavoidable; aving pressure sores any treatment and services to a prevent infection and tes from developing.  Action, record review, and actility failed to ensure re planned for prevention so to the heels, and the action and test to proper functioning alternating pressure inued healing of pressure ceient practice affected 2 viewed related to pressure te of 6. (Residents D and	F03		F-314 It is the practice of this provider to ensure that resider who enter the facility without pressure sores does not devel pressure sores unless the individual clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receive necessary treatment and servi to promote healling, prevent infection and prevent new sore from developing. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident D's hear intact and has a Z-flow pressure relief cushion for hee Resident's plan of care has be updated as well as the c.n.a. assignment sheet to include the heels up device. Resident Estage IV mattress was change out and is working properly. How other residents having to potential to be affected by the	op s ces es es els els. een ee d the	08/29/2012	
	LPN #4 and CNA During interview	A #3 from chair to bed. v at this time, LPN #4			stage IV mattress was change out and is working properly. How other residents having t	d :he e		

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Facility ID: 000110

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DING	00	COMPLETED	
		155203		LDING		07/30/2012	
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ARKS AVE		
	ST VILLAGE			JEFFER	RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLET	ION
TAG		R LSC IDENTIFYING INFORMATION)		TAG		22	
	heels on both fe	et, and indicated the heels			identified and what corrective		
	were "a little so	ft." She indicated the			action(s) will be taken? A		
	heels were being	g treated with skin prep.			residents have the potential to		
		completed, the resident			affected by the alleged deficie		
		not want to get back up			practice. · Nursing staff will I in-serviced on or before 8/27/		
					on skin management/devices		
		unch, since he had been in			Post test included.	.	
		reakfast. No pressure			Non-compliance with these		
	relief was provid	ded for the resident's			practices will result in further		
	heels, and the he	eels were directly on the			education including disciplina	ry	
	1	taff completed care at			action. Director of nursing		
	12:35 p.m.	1			services/designee is responsi		
	12.55 p.iii.				to ensure compliance. What		
	0.7/05/10 +4.05				measures will be put into pl		
		05 p.m., Resident D was			or what systemic changes w	/ill	
		. The resident's heels			be made to ensure that the		
	were directly on	the mattress.			deficient practice does not	_	
					recur? · Nursing staff will b in-serviced on or before 8/27/		
	The clinical reco	ord for Resident D was			on skin management/devices		
		5/12 at 2:25 p.m.			Post test included. The cha		
	15/16/104 011 //2	o, 12 at 2.20 p.m.			nurse is responsible for making		
	The Date of M.	and Diel- Assessment			daily rounds to ensure device		
		ound Risk Assessment,			are in place and treatments a		
		ndicated, "If the			completed as ordered. · Wou		
	answeris 'Yes'	, the resident is at risk for			team will continue to make		
	developing skin	breakdown" The			rounds on a weekly basis to		
	resident's assess	ment indicated "Yes" to			ensure devices in place and		
		ling, but not limited to,			treatments are completed as		
	_	nestions: "Does the			ordered and physicians are notified as changes are identi	fied	
		own in bed or chair?" and			Non-compliance with this	iicu.	
					procedure and re-education v	<sub>vill</sub>	
		ent have a history of			result in further training include		
	pressure wounds	s?"			disciplinary action · The Dire		
					of Nursing/designee will be		
	The At Risk for	Impaired Skin Integrity			responsible to ensure		
		nally dated 2/28/12, and			compliance. How the		
		odated 5/29/12, included			corrective action(s) will be		
		The state of the s			maintained to ensure the		
	no interventions	specific to relieving			deficient practice will not re	cur.	

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-	OF CORRECTION	IDENTIFICATION NUMBER:  155203	A. BUIL B. WIN	DING	00	COMPL: 07/30/	ETED
	PROVIDER OR SUPPLIER		•	203 SP/	ADDRESS, CITY, STATE, ZIP CODE ARKS AVE RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	and interim order indicate the resid order for skin pre July 2012. Durin at 8:40 a.m., the checked the resid Administration R resident did not he prep to the heels.  During interview on 7/30/12, comp Director of Nursi added a Z-flow p the resident after heels was brough also indicated the her.  2. On 7/26/12 at was observed in hinflated specialty unit for the Stage Pressure Relief a therapeutic mattr foot of the bed, a panel on the unit Social Services I and observed the thought maybe the	on the physician rewrite as fur July 2012 failed to ent had a physician's ep to the heels during ag interview on 7/30/12 Medical Records Nurse lent's Treatment accord and indicated the nave an order for skin at the Exit Conference pleted at 9:00 a.m., the ang indicated she had ressure relief cushion for the concern about the at to her attention. She heels did not feel soft to 9:50 a.m., Resident E her room lying on an amattress. The control of IV 2000 Alternating			i.e., what quality assurance program will be put into place. A CQI audit for specialty mattress and skin manageme will be completed weekly for weeks, monthly for 6 months then quarterly thereafter. Findings from the CQI process will be reviewed monthly and a action plan will be implemented for threshold below 95%.	ent 4 5	

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	OF CORRECTION	IDENTIFICATION NUMBER:  155203	ICATION NUMBER:  A. BUILDING  O			COMPLETED 07/30/2012	
			B. WIN		DDDESS OF STATE ZID CODE	0.700	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ARKS AVE		
HILLCRE	ST VILLAGE				RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	•	of time. Two of the					
	_	members entered the					
		ed the lights on the					
		panel are always on. The					
		ng entered the room and					
		flating - it's a Stage IV					
		he Social Services					
		the red switch on the side					
	-	rol unit, and the sound of					
	blowing air starte	ed.					
	During interview	completed on 7/26/12 at					
	10:50 a.m., the te	echnician from the					
	specialty bed con	npany supplying the					
	-	r Resident E indicated					
	_	or the bed was not					
	working properly	, and he was changing					
		indicated the mattress					
		the alternating air					
		attress was not working					
	•	chnician indicated					
	without the altern						
		ing, the mattress was					
		air mattress you have in					
		e. The technician					
		replacing the control					
		ating function of the					
	mattress would b	•					
	manicos would b	vom working.					
	The clinical reco	rd for Resident E was					
	reviewed on 7/26	5/12 at 11:50 a.m. The					
		the resident was admitted					
	3/27/12 from the						
		pitalized and readmitted					
	1 ,	•					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION  00	COM	TE SURVEY MPLETED
	155203	B. WING		07/	30/2012
	PROVIDER OR SUPPLIER EST VILLAGE	203 SP	ADDRESS, CITY, STATE, ZIP CO ARKS AVE RSONVILLE, IN 47130	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	on 4/2/12.  The most recent Physician's Orders, dated for June 2012, and signed by the Nurse Practitioner on 6/11/12, included, but were not limited to, an order, originally dated 3/28/12, for "Resident to have low air mattress every shift R/T [related to] wounds."  The Impaired Skin Integrity Care Plan, originally dated 4/2/12, and most recently updated 7/17/12, indicated interventions for the resident's pressure wounds including, but not limited to, "Pressure reducing/redistributing mattress on bed."  The Pressure Wound Skin Evaluation Report indicated on 7/21/12, the resident had a Stage IV wound to the coccyx with length of 1.3 cm, width of 1.0 cm, and depth of 0.5 cm with tunneling at 11 o'clock of 1.3, at 10 o'clock of 1.1, and at 3 o'clock of 2.0.  During interview on 7/26/12 at 1:15 p.m., RN #6 indicated Resident E had been scheduled for the first appointment at a wound clinic for evaluation of the wound on her coccyx on "last Friday [7/20/12]." She indicated the clinic had canceled the appointment and rescheduled for 7/27/12.				

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	(X3) DATE SURVEY  COMPLETED				
	155203	A. BUILDING B. WING	00	07/30/2012			
			ADDRESS, CITY, STATE, ZIP CODE				
NAME OF F	PROVIDER OR SUPPLIER	203 SPARKS AVE					
HILLCRE	ST VILLAGE	JEFFEF	RSONVILLE, IN 47130				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE			
1710	p.m., LPN #8 was observed changing the	1710	·	DATE			
	dressing to the coccyx wound. During						
	interview at this time, the resident						
	indicated the wound hurt when the						
	dressing was changed, and the resident						
	was observed to wince as LPN #8 gently						
	inserted and pushed normal saline soaked						
	gauze into the wound. LPN #8 indicated						
	the gauze packing strip was about 6						
	inches in length, and that the wound had						
	not changed significantly since the						
	resident was admitted to the facility. She						
	indicated the wound never had much						
	drainage						
	3.1-40(a)(2)						
	3.1-40(a)(2)						
			1	<u> </u>			

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Event ID: MOOX11

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PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX RESULATORY OR LSC IDENTIFYING INFORMATION) PREFIX RESULATORY OR LSC IDENTIFYING INFORMATION)  FO315 SS=D NO CATHETER, PREVENT UTI, RESTORE  REGULATORY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COMPLETED  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  COMPLETED  TAG  TAG  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
NAME OF PROVIDER OR SUPPLIER  HILLCREST VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F0315 483.25(d) SS=D NO CATHETER, PREVENT UTI, RESTORE  STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130  (X5) (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETE C	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			ETED	
NAME OF PROVIDER OR SUPPLIER  HILLCREST VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  FO315 483.25(d) SS=D NO CATHETER, PREVENT UTI, RESTORE  STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130  (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)  FO315 483.25(d) SS=D NO CATHETER, PREVENT UTI, RESTORE			155203				07/30/	2012
HILLCREST VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F0315 483.25(d) SS=D NO CATHETER, PREVENT UTI, RESTORE	NAME OF B	DOMBER OF GUIDNIES		_		ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  FO315 483.25(d) SS=D NO CATHETER, PREVENT UTI, RESTORE	NAME OF P	ROVIDER OR SUPPLIER	ER .		203 SP/	ARKS AVE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX RS=D NO CATHETER, PREVENT UTI, RESTORE  PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  COMPLETED CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COMPLETED COMPLE		ST VILLAGE			JEFFEF	RSONVILLE, IN 47130		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F0315 483.25(d) SS=D NO CATHETER, PREVENT UTI, RESTORE								(X5)
F0315 483.25(d) SS=D NO CATHETER, PREVENT UTI, RESTORE		*				CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
SS=D NO CATHETER, PREVENT UTI, RESTORE			R LSC IDENTIFYING INFORMATION)		IAG	DEFICIENC!)		DATE
Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F0315	483.25(d) NO CATHETER BLADDER Based on the resident who entindwelling cather the resident's clithat catheterizatiresident who is i receives approprious prevent urinar restore as much possible. Based on record facility failed to required a Foley retention had the and that care was potential for urindeficient practice reviewed related sample of 6. (Refindings included The clinical recording reviewed on 7/25.) Nurse's Notes for 8:30 a.m., indicated the nausea and incresident indicated the nausea and incresident.	esident's comprehensive e facility must ensure that a nters the facility without an eter is not catheterized unless linical condition demonstrates ation was necessary; and a incontinent of bladder priate treatment and services ary tract infections and to the normal bladder function as different existence of the resident who be ensure a resident who by catheter for urinary the catheter removed timely as planned related to the ensure and the resident different existence of the resident for the resident for the resident formulation and the resident formulation and feeling the resident complained of the resident complained of the resident formulation and feeling the resident complained of resident abdominal pain and feeling the resident complained of resident abdominal	F03		F-315 It is the practice of this facility to ensure that a resider who enters the facility without indwelling cathetar is not catheterized unless the reside clinical condition demonstrates that catheterization was necessary; and a resident who incontinent of bladder receives appropriate treatment and services to prevent urinary tracinfections and to restore as mormal bladder function as possible. What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice? Resident F's Fole catheter has been discontinue How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All resident's have the potential to affected by the alleged deficient practice. Licensed nurses	an  nts s o is ct uch  for ey d. e	08/29/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:		00	COMPLETED	
	155203	A. BUILDING	<del></del>	07/30/2012	
		B. WING	ADDRESS SITE STATE SID CODE		
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE		
			ARKS AVE		
HILLCRI	EST VILLAGE	JEFFE	RSONVILLE, IN 47130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG		5.112	
	administered, and a call was placed to the		catheter policy/procedure and		
	physician. At 12:30 p.m., the resident		timely physician notification b	y the	
	continued to complain of abdominal		DNS/designee no later than 8/27/12. Post test included.		
	discomfort, and a second call was placed		Non-compliance will result in		
	to the physician.		further education including		
	to the physician.		disciplinary action.		
			DNS/designee is responsible	to	
	Nurse's Note on 6/26/12 at 12:40 p.m.,		ensure compliance. What		
	indicated, "N/O's [new orders] rec'd		measures will be put into place	e or	
	[received] et [and] noted to anchor 16 Fr		what systemic changes will be		
	[french]. F/C care cc F/C [Foley catheter]		made to ensure that the effici-		
	to BSD [bedside drainage]. Dx [diagnosis] urinary retention. Monitor		practice does not recur? · Al		
			licensed nurse were in-service	ed	
			on Foley catheter		
	output X 3 days, then notify MD. F/C		policy/procedure and timely physician notification by the		
	care q shift"		DNS/designee no later than		
			8/27/12. Post test included.		
	A Nurse's Note on 6/26/12 at 3:00 p.m.,		Residents with foley cathetar	will	
	indicated the Foley catheter was anchored		be further reviewed by the DN		
	with 250 cc golden yellow urine		/Designee to ensure Physicia		
	immediately returned.		orders are followed timely and	d	
	infinediately returned.		careplan updated as needed.		
			Non-compliance will result in		
	A Nurse's Note on 6/29/12 at 2:30 p.m.,		further education including		
	indicated, "Outputs for past 3 days		disciplinary action.		
	forwarded to [name of resident's		DNS/designee responsible to ensure compliance. How the		
	physician's] office. Awaiting return call."		corrective action(s) will be		
			monitored to ensure the defic	ient	
	Documentation in Nurse's Notes,		practice will not recur, i.e., wh		
	<u> </u>		quality assurance program wi	ll be	
	Physician Progress Notes, and Physician's		put into place? The CQI a	udit	
	Telephone Orders failed to indicate the		tool for catheter assessment		
	physician's response to the forwarded		be utilized weekly x 4 weeks	and	
	information.		monthly for 6 months and		
			quarterly thereafter for any		
	A Nurse's Note on 6/29/12 at 4:00 p.m.,		resident identified from new orders, 24hour report sheets,	and	
	indicated the Nurse Practitioner visited,		documentation reviewed.	anu	
	·		Findings from the CQI proces	s	
	but the note did not indicate a response to	1	I manigo nom the own proces	· ·	

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155203			A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPL 07/30	ETED
	PROVIDER OR SUPPLIER		B. WINC	STREET A	ADDRESS, CITY, STATE, ZIP CODE  ARKS AVE RSONVILLE, IN 47130	1 01700	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	<b>_</b> 1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
TAG	the forwarded in  The Physician's 16/29/12, did not catheter and forw  The Physician's 17/14/12, indicate had Foley cath [6] Wishes to have respectively [Assessment/Plate Trial remove Folewith] prn [as need retention."  A Physician's Teteron and the second of the seco	Progress Note, dated address the Foley varded information.  Progress Note, dated d., "S [subjective]:Has eatheter] in for 3 weeks. emovedA/P in]Urinary retention - ey Monitor [symbol for ded] straight cath for  lephone Order, dated d., but was not limited to, nue] Foley Monday raight cath q shift [every for hours]) prn. If has to a re-anchor Foley." The exection of the ohone Order form was  re plans were in a plastic ical record. The care dicate a plan related to ent of the resident related ation of the Foley ong monitoring for		IAG	will be reviewed monthly and action plan will be implement for threshold below 95%.		DATE

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	of correction identification number:  155203	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMPLETED 07/30/2012			
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE  203 SPARKS AVE  JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION			
IAG	RN #6 indicated Resident F lets staff know about her needs, including toileting needs. The nurse indicated the resident is assisted to toilet throughout the day, so they know if she voids.  During interview on 7/26/12 at 2:30 p.m., the Director of Nursing indicated there was no care plan related to monitoring Resident F for urinary retention.  3.1-41(a)(1)	IAG	DEFICIENCY)	DATE			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPLETED	
		155203	B. WING		<del></del>	07/30/	2012
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ARKS AVE		
HILLCRE	ST VILLAGE				RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	483.25(h) FREE OF ACCIE HAZARDS/SUPE The facility must environment rem hazards as is por receives adequar assistance devic Based on observatinterview, the face effective interver resident's attempt assistance for fale deficient practice reviewed related (Resident A)  Findings include  During observating p.m., the sound of from the hallway room door of Residently the resident's bed. The was behind the hof his reach. The you hear that?" in sound. The resident alarm be silenced	DENT ERVISION/DEVICES ensure that the resident tains as free of accident sible; and each resident te supervision and es to prevent accidents. ation, record review, and cility failed to ensure ntions to alert staff to a t to arise without Is prevention. The e affected 1 of 2 residents to falls in a sample of 6.	F032	TAG	CROSS-REFERENCED TO THE APPROPRIAT	ce: n at t . I to ent be nt vill s. ctor s nce ctor s nce ctor	
		ait for the nurse to assist			Post test included. · Audit wa		
	_	o rise from bed, the			completed on all fall risk reside		
	min as no trica to	, rise from oed, the			to ensure interventions were in	1	

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Event ID: MOOX11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED	
		155203	A. BUI B. WIN			07/30/2012	
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8					
HILLCRE	ST VILLAGE			203 SPARKS AVE JEFFERSONVILLE, IN 47130			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	resident indicate	d, "Call one of them."			place and functioning, current		
	The resident questioned multiple times about the sounding alarm, which he				their plan of care as well as the	e	
					c.n.a. assignment sheet.		
		d in his hand, and about			Alarms are checked daily for		
		indicated, "I wish I			function and placement by the charge nurse through daily		
					rounds. · Non-compliance wi	<sub>II</sub>	
		could go [to the restroom] in my pants."			result in further education		
		NA #7 was observed			including disciplinary action.		
		e hall. As she neared the			The Director of Nursing/design	nee	
	doorway of Resident A's room, she became aware of the sounding alarm, entered and silenced the alarm, and				is responsible to ensure		
					compliance. How the correct	ve	
					action(s) will be monitored to ensure the deficient practice w	vill	
	assisted the resid	lent to the toilet.			not recur: • The CQI audit too		
					for fall management will be	<i>"</i>	
	During interview	v at this time, CNA #7			utilized weekly x 4 weeks,		
	_	resident's bed alarm was			monthly x 6 months. Finding	gs	
					from the CQI process will be		
		the head of the bed			reviewed monthly and an action	n	
	•	, with the clip behind the			plan will be implemented for		
	resident.				threshold below 95%.		
	The clinical reco	ord for Resident A was					
	reviewed on 7/20	6/12 at 9:00 a.m.					
	Nurse's Notes or	1 5/16/12 at 10:30 a.m.,					
		s [resident] noted sitting					
	on floor on butto						
		asked what happened et					
	[and] he stated, '	I went pee"					
	The Interdiscipli	nary Progress Notes,					
	dated 5/17/12 at	10:00 a.m., indicated,					
		fall on 5/16/12 @ 10:30					
		nwitnessed. Resident was					
		chair in hallway next to					
	_						
	ine medication c	art. Resident got up to					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155203	A. BUII B. WIN	LDING	00 	COMPLETED 07/30/2012	
	PROVIDER OR SUPPLIER		p. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE ARKS AVE RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR take himself to th He was found sit	CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) The bathroom per resident. The bathroom per resident.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE.	(X5) COMPLETION DATE
	on. Fall was in the restroomInterv	rention started is a clip has history of trying to					
	7/11/12 at 5:45 p resident experien in his room besid to question #13 in	nce Report, dated .m., indicated the ced an unwitnessed fall le the bed. The response indicated, "Res told this ing to bed et [and] my leg					
	and updated on 6 indicated the resi Approaches includimited to, "Call I low bed with mat positionPlace of (5/16/12)Offer	riginally dated 4/11/12, /26/12 and 7/12/12, dent was at risk for falls. ided, but were not light in reach (4/11/12), it on floor, bed in lowest clip alarm to wheel chair it to assist to bed [symbol The plan did not e alarm in bed.					
	Conference on 7/ Director of Nursi in Resident A's a	at the Daily Exit 27/12 at 5:00 p.m., the ing indicated the battery larm might need to be s sound is not very					

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Event ID: MOOX11

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:  155203	A. BUILDING  B. WING	00	COMPLETED 07/30/2012			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
HILLCRE	ST VILLAGE		203 SPARKS AVE JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	3.1-45(a)(2)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155203			(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/30/2012
	PROVIDER OR SUPPLIER		203 SI	ADDRESS, CITY, STATE, ZIP CODE PARKS AVE ERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	483.65 INFECTION COI SPREAD, LINEN The facility must Infection Control provide a safe, s environment and	NTROL, PREVENT IS establish and maintain an Program designed to anitary and comfortable I to help prevent the d transmission of disease			
	The facility must Control Program (1) Investigates, infections in the (2) Decides what isolation, should resident; and (3) Maintains a re	establish an Infection under which it - controls, and prevents			
	(1) When the Info determines that a prevent the sprea must isolate the (2) The facility m communicable d lesions from dire their food, if direc disease. (3) The facility m hands after each	ust prohibit employees with a isease or infected skin ct contact with residents or ct contact will transmit the ust require staff to wash their direct resident contact for hing is indicated by accepted			
	transport linens s of infection. Based on observa	handle, store, process and so as to prevent the spread ation, interview, and e facility failed to ensure	F0441	F441 It is the practice of this provider to ensure that the	08/29/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIIII I	a. building 00		COMPLETED	
		155203	B. WING			07/30/	2012
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ARKS AVE		
HILLCRE	EST VILLAGE				RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
		fection control policies			resident environment remains		
	for handwashing and glove use during 1				free of accident as possible; a each resident receives adequ		
	of 4 observation	s of direct resident care			supervision and assistance	aic	
	for 6 sampled re	sidents. (Resident B)			devices to prevent accidents.		
					What corrective action(s) will	be	
	Findings include	2:			accomplished for those reside		
	30				found to have been affected b	у	
	On 7/25/12 at 4:	00 p.m., LPN #2 was			the deficient practice?		
		-			Resident B was not affected be the alleged deficient practice at	-	
	seated at the nurse's station writing in				the rash is resolved How oth		
	charts. During interview, LPN #2				residents having the potential		
	indicated Resident B had rash areas on his				be affected by the same defic		
		which he thought might be			practice will be identified and		
	heat-related, since	ce the resident likes to			what corrective action(s) will be		
	wear long sleeve	es and a jacket, even in			taken? · All resident's have		
	hot weather. Up	oon request, LPN #2 was			potential to be affected by the alleged deficient practice.		
	observed assessi	ng the skin on the right			Nursing staff has been		
		and right upper arm of			in-serviced on washing hands		
		N #2 left the nurse's			and glove use by the		
		m the assessment, and			DNS/designee on or before		
	_	this hands, using hand			8/27/12. Post test included.		
					Non-compliance with these		
		lying gloves, he assisted			practices will result in further education including disciplinal	·v	
		djust his clothing so areas			action. · Director of nursing	,	
		er chest and right upper			services/designee is responsi	ble	
		e. As LPN #2 was			to ensure compliance. What		
	showing the area	as, he touched the			measures will be put into place		
	resident's chest a	and arm with ungloved			what systemic changes will be		
	hand. After the	assessment, LPN #2			made to ensure that the defici practice does not recur?	ent	
	assisted the resid	lent to readjust his			Nursing staff has been		
		the room without			in-serviced on washing hands		
		ds or using hand sanitizer.			and glove use by the		
	, asimis the num	as or using name summer.			DNS/designee on or before		
	The clinical rese	ord for Resident B was			8/27/12. Post test		
					included. Handwashing skil		
	reviewed on 1/2.	5/12 at 1:25 p.m.			checklist will be conducted for licensed staff by the		
					l licerised stail by tile		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155203	B. WIN		<del></del>	07/30/	2012
			D. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ARKS AVE		
HILLCRE	EST VILLAGE				RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·		DATE
	1	Progress Note, dated			DNS/Designee to ensure understanding of Infection Cor	ntrol	
	7/20/12, indicated, "S [subjective]: Rash				practices. · Non-compliance v		
		A [right upper arm]			these practices will result in		
	pruritic noticed b	by staff & pt [patient]			further education including		
	today. O [objecti	ive]: Confluent spotty			disciplinary action. Director	of	
	pink dry papular	rash A/P			nursing services/designee is		
	[Assessment/Pla	n]: Eczema -			responsible to ensure compliance. How the correcti	ve	
	Betamethasone [	hydrocortisone for			action(s) will be monitored to	••	
	itching] cream BID [twice daily]."  The Physician's Telephone Order, dated 7/20/12, indicated, "Betamethasone cream				ensure the deficient practice w	rill	
					not recur, i.e., what quality		
					assurance program will be put		
					into place? The CQI skills validation tool for hand washin	a	
	1	D X [times] 7d [days]			and glove use will be utilized	9	
	Dermatitis."	5 / [times] / a [aays]			weekly x 4 weeks, monthly x 6		
	Definations.				months and quarterly thereafte		
	On 7/26/12 at 4.	15 41. a C4 a CC			· Findings from the CQI proce		
		15 p.m., the Staff			will be reviewed monthly and a		
	_	oordinator (SDC)			action plan will be implemente as needed for any deficient	u	
	_	nd Hygiene Skills Check			practices below the 95%		
		aff were expected to			threshold.		
		list when providing care.					
		neck list indicated, "Note:					
	5 moments of re	quired hand hygiene:					
	before patient [s:	ic]after patient					
	contact"						
	On 7/26/12 at 4:	50 p.m., the SDC					
	provided page 4	of from what he					
	indicated was the	e Infection Control					
	Manual. Review	v of the document					
	indicated, "Glov	es:Wear gloves					
		ng resident's skin or					
	surfaces close to	•					
		100140110					
	The federal tag r	relates to Complaint					

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155203		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COM	(X3) DATE SURVEY COMPLETED 07/30/2012	
NAME OF F	PROVIDER OR SUPPLIEF	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP	CODE		
HILLCREST VILLAGE			203 SPARKS AVE JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  COMI		(X5) COMPLETION DATE	
	IN00112898.		-				
	IN00112898. 3.1-18(I)						

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